## PRIOR AUTHORIZATION REQUEST

MassHealth

MassHealth reviews requests for prior authorization on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision.

Executive Office of Health and Human Services Office of Medicaid

Complete Items 1-17 only. See Subchapter 5 of your provider manual for detailed instructions on completing this form.

PROVIDER INFORMATION SECTION							MEMBER INFORMATION SECTION							
I. PROVIDER'S NAME AT	ND ADDRESS						4. MEN	IBER'S NAME	AND ADDRE	SS			$\neg$	OF RESIDEN
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2. PROVIDER'S TELEPHONE NO.							6. SEX 7. OTHER INSURANCE 8. NAME OF INSURANCE CARRIER							
(   )    -							□ M         □ F         □ Yes         □ No							
3. PROVIDER NO.							9. DAT	E OF BIRTH		10. MEI	MBER NO.			
														$\overline{1}$
11. EXPLAIN WHY THIS	SERVICE IS ME	DICALLY NE	CESSARY. IN	CLUDE THE DIAG	GNOSIS AND A	A DESCRIP	TION OF T	HE PROPOSE	)					
TREATMENT. ATTACH	SUPPORTING	DOCUMENTA	ATION IF REQU	JIRED BY MASSI	HEALTH REGU	LATIONS.								
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12. SERVICE CODE (USE A SEPARAT	E LINE FOR E/		13. NO. OF UNITS	14. DURATION (DAYS)	18. REVIEWE		EVISED SI			20. NO. OF UNITS	21. TIME LIMIT (DAYS)	22. UNIT FEE	2	3. DENIAL REASON I
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15. PROVIDER'S SIGNAT	TI IDE					4. DATE O	E DECEIDT		25 EVD	IRATION DATE		26. DATE OU	IT	
13. FROVIDER 3 SIGNAL	OKE					4. DATE O	RECEIPT	1 1	23. EXP	IKATION DATE	1 1	20. DATE 00	1 1	1 1
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30. COMMENTS OR REA	ASONS FOR DE	NIAL, MODIF	ICATION, OR	DEFERRAL					31. DAT	E OUT - CLEI	RICAL	32. DATE RI	ETURNED	
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